Missouri Medicaid Ambulance Billing Book

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Preface

This Ambulance training booklet contains information to help you submit claims correctly. The information is only recommended for Missouri Medicaid providers and billers if your Medicaid provider number begins with 80. The booklet is not all-inclusive of program benefits and limitations; providers should refer to specific program manuals for entire content.

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SECTION 1
MEDICAID PROGRAM RESOURCES
Informational Resources available at www.dss.mo.gov/dms

CONTACTING MEDICAID

PROVIDER COMMUNICATIONS

The following phone numbers are available for Medicaid providers to call with inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and recipient eligibility questions and verification. The (573) 635-8908 number provides an interactive voice response (IVR) system that can address recipient eligibility, last two check amounts and claim status inquiries. Providers must use a touchtone phone to access the IVR. There is no option to be transferred to the Provider Communications Unit from the IVR. See page 1.3 for more information on the IVR.

Provider Communications	(573) 751-2896
Interactive Voice Response (IVR)	(573) 635-8908

The Provider Communications Unit also processes written inquires. Written inquiries should be sent to:

Provider Communications Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

INFOCROSSING HEALTHCARE SERVICES, INC. HELP DESK
(573) 635-3559

Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements and assistance with the Infocrossing Internet billing service.

PROVIDER ENROLLMENT

Providers can contact Provider Enrollment via e-mail as follows for questions regarding enrollment applications: providerenrollment@dss.mo.gov.

Changes regarding address, ownership, tax identification number, name (provider or practice), or Medicare number must be submitted in writing to:

Provider Enrollment Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

THIRD PARTY LIABILITY
(573) 751-2005
Call the Third Party Liability Unit to report injuries sustained by Medicaid recipients, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a Medicaid recipient.

PROVIDER EDUCATION
(573) 751-6683
Provider Education Unit staff are available to educate providers and other groups on proper billing methods and procedures for Medicaid claims. Contact the Unit for training information and scheduling.

RECIPIENT SERVICES
(800) 392-2161 or (573) 751-6527
The Recipient Services Unit assists recipients regarding access to providers, eligibility, covered and non-covered services and unpaid medical bills.

MEDICAID EXCEPTIONS AND DRUG PRIOR AUTHORIZATION HOTLINE
(800) 392-8030
Providers can call this toll free number to initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the Medicaid program, or to request a drug prior authorization. The Medicaid exceptions fax line for non-emergency requests only is (573) 522-3061; the fax line to obtain a drug prior authorization is (573) 636-6470.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) INFORMATION

Billing providers who want to exchange electronic information transactions with Missouri Medicaid can access the *HIPAA-EDI Companion Guide* online by going to the Division of Medical Services Web site at www.dss.mo.gov/dms and clicking on the “Providers” link at the top of the page. On the Provider Participation page, click on the HIPAA-EDI Companion Guide link in the column on the left hand side of the page. This will take you directly to the EDI Companion Guide and X12N Version 4010A1 Companion Guide links.

For information on the Missouri Medicaid Trading Partner Agreement, click on the link to Section 1- Getting Started, then select Trading Partner Registration.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Infocrossing Healthcare Services Help Desk, (573) 635-3559.

INTERACTIVE VOICE RESPONSE (IVR)
(573) 635-8908

The Provider Communications Unit Interactive Voice Response (IVR) system, (573) 635-8908, requires a touchtone phone. The nine-digit Medicaid provider number **must** be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

Option 1 Recipient Eligibility

Recipient eligibility **must** be verified **each** time a recipient presents and should be verified **prior** to the service. Eligibility information can be obtained by a recipient's Medicaid number (DCN), social security number and date of birth, or if a newborn, using the mother's Medicaid number and the baby's date of birth. Callers cannot inquire on dates that exceed one year prior to the current date. Callers will be given a confirmation number and this number should be kept as proof of the information received.

Option 2 Last Two Check Amounts

Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.

Option 3 Claim Status

After entering the recipient's Medicaid number (DCN) and the date of service, the caller will be provided the status of the most current claim in the system containing the date of service entered. The caller will be told whether the claim is paid, denied, approved to pay or is being processed. In addition, the system will give the amount paid, the RA date and the Internal Control Number (ICN).

INTERNET SERVICES FOR MEDICAID PROVIDERS

The Division of Medical Services (DMS), in cooperation with Infocrossing Healthcare Services, has an Internet service for Missouri Medicaid providers. Missouri Medicaid providers have the ability to:

- Submit claims and receive claim confirmation files;
- Verify recipient eligibility;
- Obtain remittance advices (RAs);
- Submit adjustments;
- Submit attachments;
- View claim, attachment and prior authorization (PA) status; and
- View and download public files.

The Web site address for this service is www.emomed.com. Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the Web site services. To participate in the service, the provider must apply on-line at www.dss.mo.gov/dms. Each user is required to complete this on-line application in order to obtain a user ID and password. The application process only takes a few minutes and provides the applicant with a real-time confirmation response, user ID and password. Once the user ID and password have been received, the user can begin using the www.emomed.com Web site. The password can be changed to one of the user's own choice.

Questions regarding the completion of the on-line Internet application should be directed to the Infocrossing Healthcare Services Help Desk, (573) 635-3559.

An authorization is required for each individual person within a provider's office or a billing service who will be accessing the Internet site.

This Web site, www.emomed.com, allows for the submission of the following HIPAA compliant transactions:

837 Institutional Claims	Batched or Individual
837 Professional Claims	Batched or Individual
837 Dental Claims	Batched or Individual
270 Eligibility Inquiry	Batched or Individual
276 Claim Status Inquiry	Batched or Individual

The following standard responses are generated:

835 Remittance Advice	Batch or Printable RA
271 Eligibility Response	Batch or Individual
277 Claim Status Response	Batch or Individual

Users also have access to provider check amounts and the Claims Processing Schedule for the current fiscal year.

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements. However, the user (provider) must have the proper Web browser. The provider must have one of the following Web browsers: Internet Explorer 5.0 or higher or Netscape 4.7 or higher. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

VERIFYING RECIPIENT ELIGIBILITY THROUGH THE INTERNET

Providers can access Missouri Medicaid recipient eligibility files via the Web site. Functions include eligibility verification by recipient ID, casehead ID and child's date of birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occurs in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

A batch eligibility confirmation file can either be downloaded for viewing purposes or to be printed.

MEDICAID CLAIMS SUBMISSION THROUGH THE INTERNET

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

- 837 - Health Care Claim
  - Professional
  - Dental
  - Institutional (hospital inpatient and outpatient, nursing home, and home health care)
- Pharmacy (NCPDP)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

A batch claim confirmation file can either be downloaded for viewing purposes or to be printed.

Claims requiring the attachment of a trip ticket cannot be submitted electronically and must be submitted paper with the trip ticket attached to the claim form.

OBTAINING A REMITTANCE ADVICE THROUGH THE INTERNET

The Medicaid program phased out the mailing of paper Remittance Advices (RAs). Providers no longer will receive both paper and electronic RAs. If the provider or the provider's billing service currently receives an electronic RA, (either via the emomed.com Internet Web site or other method), paper copies of the RA were discontinued. All providers and billers must have Internet access to obtain the printable electronic RA via the Infocrossing Internet Service, emomed.com.

Receiving the Remittance Advice via the Internet is beneficial to the provider or biller's operation. With the new Internet RA, a user can:

- Retrieve the RA the Monday following the weekend claim processing cycle (two weeks earlier than receipt of the paper RA);
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from the desktop; and,
- Download the RA into the provider or biller's operating system for retrieval at a later date.

The new Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the computer system for printing at the user's convenience.

To sign up for this service, see the instructions at the beginning of this information on Internet services. If a provider does not have access to the Internet, contact the Infocrossing Help Desk, (573) 635-3559, to learn how to obtain a paper remittance.

ADJUSTMENTS THROUGH THE INTERNET

Providers have options on the Internet Medical, Dental, Inpatient, Outpatient and Nursing Home claims for a "Frequency Code" that will allow either a 7 – Replacement (Adjustment) or an 8 – Void (Credit). This will control an individual adjustment or void, but not group adjustments or voids. Claim adjustments and credits can be submitted by utilizing the CLM, field CLMO5-3, segment of the 837 Health Care Claim.

RECEIVE PUBLIC FILES THROUGH THE INTERNET

Several public files are available for viewing or downloading from the Web site including the claims processing schedule for the State fiscal year which begins July 1 and ends June 30. Providers also have access to a listing of the HIPAA related claim codes and other HIPAA related codes.

MISSOURI MEDICAID PROVIDER MANUALS AND BULLETINS ON-LINE
www.dss.mo.gov/dms

Missouri Medicaid provider manuals are available on-line at the DMS Web site, www.dss.mo.gov/dms. To access the provider manuals, click on the "Providers" link at the top of the DMS home page. Scroll to the bottom of the Provider Participation page and click on the Provider Manuals link. The next page displays an alphabetical listing of all Medicaid provider manuals. To print a manual or a section of a manual, click on the Synchronize Contents link on the left hand side of the page, this will bring you to the "Print A Manual" link. Instructions for printing manuals or sections of manuals are available through this link.

Missouri Medicaid provider bulletins are also available at the DMS Web site. The bulletins are published to notify providers of new program and policy changes or to clarify existing policy. To access the bulletins, click on the Provider Bulletin link on the Provider Participation page. The bulletins appear on-line at this location until the provider manuals are updated. Once the manuals are updated, the bulletins are moved to the Archived Bulletin location.

CLAIMS PROCESSING SCHEDULE FOR STATE FISCAL YEAR 2006

Cycle Run/Remittance Date* -	Check Date -
Friday, June 17, 2005	Tuesday, July 05, 2005
Friday, July 08, 2005	Wednesday, July 20, 2005
Friday, July 22, 2005	Friday, August 05, 2005
Friday, August 05, 2005	Monday, August 22, 2005
Friday, August 19, 2005	Tuesday, September 06, 2005
Friday, September 09, 2005	Tuesday, September 20, 2005
Friday, September 23, 2005	Wednesday, October 05, 2005
Friday, October 07, 2005	Thursday, October 20, 2005
Friday, October 21, 2005	Monday, November 07, 2005
Friday, November 04, 2005	Monday, November 21, 2005
Friday, November 18, 2005	Monday, December 05, 2005
Friday, December 09, 2005	Tuesday, December 20, 2005
Friday, December 23, 2005	Thursday, January 05, 2006
Friday, January 06, 2006	Friday, January 20, 2006
Friday, January 20, 2006	Monday, February 06, 2006
Friday, February 10, 2006	Tuesday, February 21, 2006
Friday, February 24, 2006	Monday, March 06, 2006
Friday, March 10, 2006	Monday, March 20, 2006
Friday, March 24, 2006	Wednesday, April 05, 2006
Friday, April 07, 2006	Thursday, April 20, 2006
Friday, April 21, 2006	Friday, May 05, 2006
Friday, May 05, 2006	Monday, May 22, 2006
Friday, May 19, 2006	Monday, June 05, 2006
Friday, June 09, 2006	Tuesday, June 20, 2006

*The Cycle Run Dates are tentative dates calculated by the Division of Medical Services. The dates are subject to change without prior notification.

*All claims submitted electronically to Infocrossing, must be received by 5:00 p.m. of the Cycle Run/Remittance Advice date in order to pay on the corresponding check date.

State Holidays

July 4, 2005 Independence Day
September 5, 2005 Labor Day
October 10, 2005 Columbus Day
November 11, 2005 Veteran's Day
November 24, 2005 Thanksgiving
December 26, 2005 Christmas

January 2, 2006 New Year's Day
January 16, 2006 Martin Luther King Day
February 13, 2006 Lincoln's Birthday
February 20, 2006 Washington's Birthday
May 8, 2006 Truman's Birthday
May 29, 2006 Memorial Day

SECTION 2
CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. Medicaid paper claims should be mailed to:

Infocrossing Healthcare Services, Inc.
P.O. Box 5600
Jefferson City, MO 65102

Infocrossing's physical address is:

Infocrossing Healthcare Services, Inc.
905 Weathered Rock Road
Jefferson City, MO 65101

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at **www.dss.mo.gov/dms**.

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicates a field is required in specific situations.

Field number and name		Instructions for completion
1.	Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box, if a Medicaid claim is being filed, check the Medicaid box and if the patient has both Medicare and Medicaid, check both boxes.
1a.*	Insured's I.D.	Enter the patient's eight-digit Medicaid or MC+ ID number (DCN) as shown on the patient's ID card.
2.*	Patient's Name	Enter last name, first name, middle initial *in this order* as it appears on the ID card.
3.	Patient's Birth Date	Enter month, day, and year of birth.
	Sex	Mark appropriate box.

4.**	Insured's Name	If there is individual or group insurance besides Medicaid, enter the name of the primary policyholder. If this field is completed, also complete fields 6, 7, 11, and 13. If no private insurance is involved, leave blank.
5.	Patient's Address	Enter address and telephone number if available.
6.**	Patient's Relationship to Insured	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
7.**	Insured's Address	Enter the primary policyholder's address; enter policy-holder's telephone number, if available. If no private insurance is involved, leave blank.
8.	Patient Status	Leave blank.
9.**	Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. If no private insurance is involved, leave blank. (See Note)(1)
9a.**	Other Insured's Policy or Group Number	Enter the secondary policyholder's Insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. (See Note)(1)
9b.**	Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box reflecting the sex of the secondary policyholder. If no private insurance is involved, leave blank. (See Note)(1)
9c.**	Employer's Name	Enter the secondary policyholder's employer name. If no private insurance is involved, leave blank. (See Note)(1)
9d.**	Insurance Plan	Enter the secondary policyholder's insurance plan name. If no private insurance is involved, leave blank.

	If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. (See Note)(1)
10a.-10c.** Is Condition Related to:	If services on the claim are related to patient's employment, an auto accident or other accident, mark the appropriate box. *If the services are not related to an accident, leave blank.* (See Note)(1)
10d. Reserved for Local Use	May be used for comments/descriptions.
11.** Insured's Policy or Group Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. If no private insurance is involved, leave blank. (See Note)(1)
11a.** Insured's Date of Birth	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. If no private insurance is involved, leave blank. (See Note)(1)
11b.** Employer's Name	Enter the primary policyholder's employer name. If no private insurance is involved, leave blank. (See Note)(1)
11c.** Insurance Plan Name	Enter the primary policyholder's insurance plan name. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* (See Note)(1)
11d.** Other Health Plan	Indicate whether the patient has a secondary health insurance plan. If so, complete fields 9-9d with the secondary insurance information. (See Note)(1)
12. Patient's Signature	Leave blank.
13. Insured's Signature	This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits.

		The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of Medicaid. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
14.	Date of Current Illness, Injury or Pregnancy	Leave blank.
15.	Date Same/Similar Illness	Leave blank.
16.	Dates Patient Unable to Work	Leave blank.
17.	Name of Referring Physician or Other Source	Leave blank.
17a.	I.D. Number of Referring Physician	Leave blank.
18.	Hospitalization Dates	Leave blank.
19.	Reserved for Local Use	Providers may use this field for additional remarks or descriptions.
20.	Lab Work Performed Outside Office	Leave blank.
21.*	Diagnosis	Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc.
22.**	Medicaid Resubmission	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim.
23.	Prior Authorization Number	Leave blank**.**
24a.*	Date of Service	Enter the date of service under “from” in month/day/year format, using a six-digit format. All line items must have a from date.
24b.*	Place of Service	Enter the appropriate place of service (POS) code. The place of service is the destination of the ambulance trip. A complete listing of POS codes and descriptions can be found in

		Section 15 of the MO Medicaid Ambulance manual. Do not use POS **41** (land) or POS **42** (air/water) as these codes are not valid Medicaid place of service codes. ***Ambulance claims for other than Healthy Children and Youth (EPSDT/HCY) services must use POS 21, 23, 26, 51, 55, 56 or 61. Note: POS 55, 56 and 61 are not valid for air transport.***
24c.	Type of Service	Leave blank.
24d.*	Procedure Code	Enter the appropriate HCPCS code and applicable modifier(s) corresponding to the service rendered. (field 19 may be used for remarks or descriptions.) ***Valid EPSDT/HCY claims are billed with an EP modifier.***
24e.*	Diagnosis Code	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from field 21.
24f.*	Charges	Enter the provider's usual and customary charge for each line item. This should be the total charge if multiple days or units are shown.
24g.*	Days or Units	Enter the number of units of service provided for each detail line. The system automatically plugs a "1" if the field is left blank. The units for mileage must reflect the total "loaded" mileage one way from the point of pickup to the destination.
24h.**	EPSDT/Family Planning	If the service is an EPSDT/HCY transport, enter "E".
24i.	Emergency	Leave blank.
24j.	COB	Leave blank.
24k	Performing Provider Number	Leave Blank
25.	SS#/Fed. Tax ID	Leave blank.
26.	Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.

27.	Assignment	Not required on Medicaid claims.
28.*	Total Charge	Enter the sum of the line item charges.
29.**	Amount Paid	Enter the total amount received by all other insurance resources. ***Previous Medicaid payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field.***
30.	Balance Due	Enter the difference between the total charge (field 28) and the insurance amount paid (field 29).
31.	Provider Signature	Not Required.
32.**	Name and Address of Facility	If the services were rendered in a facility other than the home or office, enter the name and location of the facility. ***This field is required when the place of service is 21, 23, 26, 51, 55, 56 or 61*.**
33.*	Provider Name/ Number /Address	Affix the provider label or write or type the information ***exactly*** as it appears on the label.

* These fields are mandatory on all CMS-1500 claim forms.

** These fields are mandatory only in specific situations, as described.

(1) NOTE: This field is for private insurance information only. If no private insurance is involved **leave blank**. If Medicare, Medicaid, employers name or other information appears in this field, the claim will deny. See Section 5 of the Medicaid *Provider's Manual* for further TPL (Third Party Liability) information.

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES PLACE (State)

NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

SECTION 3
THE REMITTANCE ADVICE

Missouri Medicaid discontinued printing and mailing paper Remittance Advices (RAs) to most providers July 20, 2004. The remittance advices are available via the Internet through emomed.com. There are two versions available, the 837 format and the Printable RA.

With the implementation of Internet Remittance Advice, providers can:

- Retrieve a remittance advice the Monday following the weekend Financial Cycle run (two weeks sooner than the paper version);
- View and print the RA from your desktop; and
- Download the RA into your computer system for future reference.

More information on accessing and using the printable RA is found later in this section.

When a claim is adjudicated, it is included as a line item on the next RA. Along with listing the claim, the RA lists an "Adjustment Reason Code" to explain a payment, denial or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's reimbursement for it. The RA may also list a "Remittance Remark Code" which is from the same national administrative code set that indicates either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code. The Adjustment Reason Codes and Remittance Remark Codes may be accessed through a link on the Division of Medical Services Web site, www.dss.mo.gov/dms and clicking on the "Providers" link. Once you are on the Provider Participation page, click on the "HIPAA-related code lists" in the Provider Quick Links box.

The date on the RA is the date the final processing cycle runs. Reimbursement will be made through a mailed check or a direct bank deposit approximately two weeks after the cycle run date. (See Claims Processing Schedule at the end of Section 1.)

The RA is grouped first by paid claims and then by denied claims. Claims in each category are listed alphabetically by the patient's last name. If the patient's name and/or Departmental Client Number (DCN) are **not** on file, only the first two letters of the last name and first letter of the first name appear.

Each claim entered into the claims processing system is assigned a 13-digit Internal Control Number (ICN) assigned for identification purposes. The first two digits of an ICN indicate the type of claim.

15 – Paper claim
40 – Electronic Medicare Crossover

49 – Internet claim
70 – Individual Credit to an Adjustment
50 – Individual Adjustment Request
75 – Credit Mass Adjustment
55 – Mass Adjustment

The third and fourth digits indicate the year the claim was received. The fifth, sixth, and seventh digits indicate the Julian date the claim was entered into the system. In the Julian system, the days are numbered consecutively from "001" (January 01) to "365" or "366" in a leap year (December 31). The last digits of an ICN are for internal processing.

The ICN 1504277315020 is read as a paper medical claim entered in the processing system on October 04, 2004.

If a claim is denied, a new or corrected claim form **must** be submitted as corrections **cannot** be made by submitting changes on the printed RA pages.

When a claim denies for other insurance, the commercial carrier information is shown. Up to two policies can be shown.

PRINTABLE REMITTANCE ADVICE

The Printable Internet Remittance Advice is accessed at www.emomed.com. A provider must be enrolled with emomed.com in order to access the Web site and the printable RA. To sign-up for emomed.com and the on-line Remittance Advice option, visit the Missouri Medicaid Web site, www.dss.mo.gov/dms, and select the Provider Information "internet access" link.

On the Printable Remittance Advice page, click on the RA date you wish to view, print or save and follow your Internet browser's instructions. The RA is in the PDF file format. Your browser will open the file directly if you have Adobe Acrobat Reader installed on your computer.

RAs are available automatically following each financial cycle. Each RA remains available for a total of 62 days. The oldest RA drops off as the newest becomes available. Therefore, providers are encouraged to save each RA to their computer system for future reference and use.

Note: When printing an RA, it is set to page break after 70 lines per page.

If a provider did not save an RA to his/her computer and wants access to an RA that is no longer available, the provider can request the RA through the "Aged RA Request" link on the emomed.com home page.

In general, the Printable Remittance Advice is displayed as follows.

Field	Description
RECIPIENT NAME	The recipient's last name and first name. NOTE: If the recipient's name and identification number are not on file, only the first two letters of the last name and first letter of the first name appear.
MEDICAID ID	The recipient's 8-digit Medicaid identification number.
ICN	The 13-digit number assigned to the claim for identification purposes.
SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider's own patient account name or number.
CLAIM: ST	This field reflects the status of the claim. Values are: 1 = Processed as Primary, 3 = Processed as Tertiary, 4 = Denied, 22 = Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount Medicaid paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), recipient copay, and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. Note: The revenue code will only appear in this field if a procedure code is not present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. Note: The revenue code only appears in this field if a procedure code has also been submitted.
QTY	The units of service submitted.
BILLED AMOUNT	The submitted billed amount for the specific detail line.
ALLOWED AMOUNT	The Medicaid maximum allowed amount for the procedure.
PAID AMOUNT	The amount Medicaid paid on the claim.
PERF PROV	The Medicaid ID number for the performing provider submitted at the detail.

Field	Description
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim Adjustment Group Code is a code identifying the general category of payment adjustment. Values are: CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PI = Payer Initiated Reductions PR = Patient Responsibility
RSN	The Claim Adjustment Reason Code is the code identifying the detailed reason the adjustment was made.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field will not be printed if the value is zero.
REMARK CODES	The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Values are: HE = Claim Payment Remark Code RX = National Council for Prescription Drug Programs Reject/Payment Codes. The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.

SECTION 4
MEDICARE CROSSOVER CLAIMS

Medicare/Medicaid (crossover) claims that do not cross automatically from Medicare to Medicaid must now be filed through the Medicaid billing Web site at www.emomed.com or through the 837 electronic claim transaction. This requirement became effective July 1, 2005. Before filing an electronic crossover claim, please wait sixty (60) days from the date of your Medicare payment to avoid possible duplicate payments from Medicaid.

There are two primary reasons claims do not cross over electronically from Medicare to Medicaid. One is because Medicaid enrolled providers have not provided Medicaid with their Medicare provider number or have provided an invalid or inactive Medicare provider number. If the provider has any doubt as to what Medicare number(s) is (are) on file, contact the Provider Enrollment Unit by e-mail at providerenrollment@dss.mo.gov. If you have not submitted your Medicare provider number to Medicaid, you can fax a copy of the Medicare letter showing the Medicare provider name and the assigned Medicare provider number along with a cover letter explaining why the information is being submitted to the enrollment unit. Provider Enrollment's fax number is (573) 526-2054. Please be certain to include your Medicaid provider name and number with any correspondence sent to Provider Enrollment.

Another reason claims do not cross over electronically is due to invalid patient information. Claims will not cross over electronically if the patient is not going by the same name with Medicare as they do with Medicaid. Additionally, the patient's Medicare Health Insurance Claim (HIC) number in the Medicaid eligibility file must agree with the HIC number used by the provider to submit the claim to Medicare. It is the responsibility of the patient to keep this information updated with their Family Support Division caseworker.

Following are tips to assist you in successfully filing a Medicare CMS-1500 Part B Crossover on the Medicaid billing Web site:

- Enter the information in the fields on the screen exactly as you did on your Medicare billing with the exception of the patient's name. The patient's name must be entered as it currently appears in the Medicaid eligibility file, not necessarily the name as shown on the Medicare remittance advice.
- There are HELP screens at the bottom of each screen page to provide instructions for completing the crossover claim screens, the "Other Payer" header and the "Other Payer" detail screens. Print each HELP screen in its entirety for reference when completing claims on the Internet.
- There must be an "Other Payer" header screen completed for every crossover claim. This provides information pertaining to the whole claim.

- There will be no group codes, reason codes or adjustment amounts entered on this screen for Part B claims.
- Completion of an "Other Payer" detail screen form is required for each claim detail line. The five (5) codes that can be entered in the "Group Code" field on the "Other Payer" detail screen form are in a drop down box, you need to choose the appropriate code. As an example, the "PR" (patient responsibility) code is assigned for Medicare coinsurance and/or deductible amounts from your Medicare remittance advice.
- The codes to enter in the "Reason Code" field on the "Other Payer" detail screen form are also found on your Medicare remittance advice. If not listed, you must choose the most appropriate code from the list of "Claim Adjustment Reason Codes". The HIPAA code lists can be accessed at the DMS home page, www.dss.mo.gov/dms. Click on the "Providers" link at the top of the page then click on the HIPAA-related Code Lists link found in the Provider Quick Links box.
- The "Adjust Amount" should reflect any amount not paid by Medicare including deductible, coinsurance and any non-allowed amounts.
- If there is commercial insurance payment or denial to report on the crossover claim, you must complete an additional "Other Payer" header form. You must also complete an additional "Other Payer" detail form(s) if the commercial carrier provided detail line information for line item payments and denials.

TIMELY FILING

Claims initially filed with Medicare within Medicare timely filing requirements and require separate filing of a crossover claim to Medicaid must meet the Medicaid timely filing guidelines for Medicare/Medicaid claims. The crossover claim must be submitted by the provider and received by the Medicaid agency within 12 months from the date of service or six months from the date on the provider's Medicare Explanation of Medicare Benefits (EOMB), whichever is later. *The counting of the six-month period begins with the date of adjudication of the Medicare payment and ends with the date of receipt.*

ADJUSTMENTS

If Medicare adjusts a claim and Medicaid has paid the original crossover claim, then the original claim payment from Medicaid must be adjusted through the Medicaid billing Web site. The "Claim Frequency Type Code" must be either a replacement (7) or a void (8). When submitting a replacement or void, the ICN (internal control number) being replaced or voided must be stated in the "Resubmission Ref. No." field. For a void claim, the only fields required for submission are the Patient Name, Patient Medicaid ID and the Resubmission Reference Number.

A sample of the Medicare CMS 1500 Part B Crossover is displayed on the following pages.

PALMETTO GBA - RAILROAD MEDICARE
P.O. BOX 10066
AUGUSTA, GA 30999-0001
1-877-288-7600

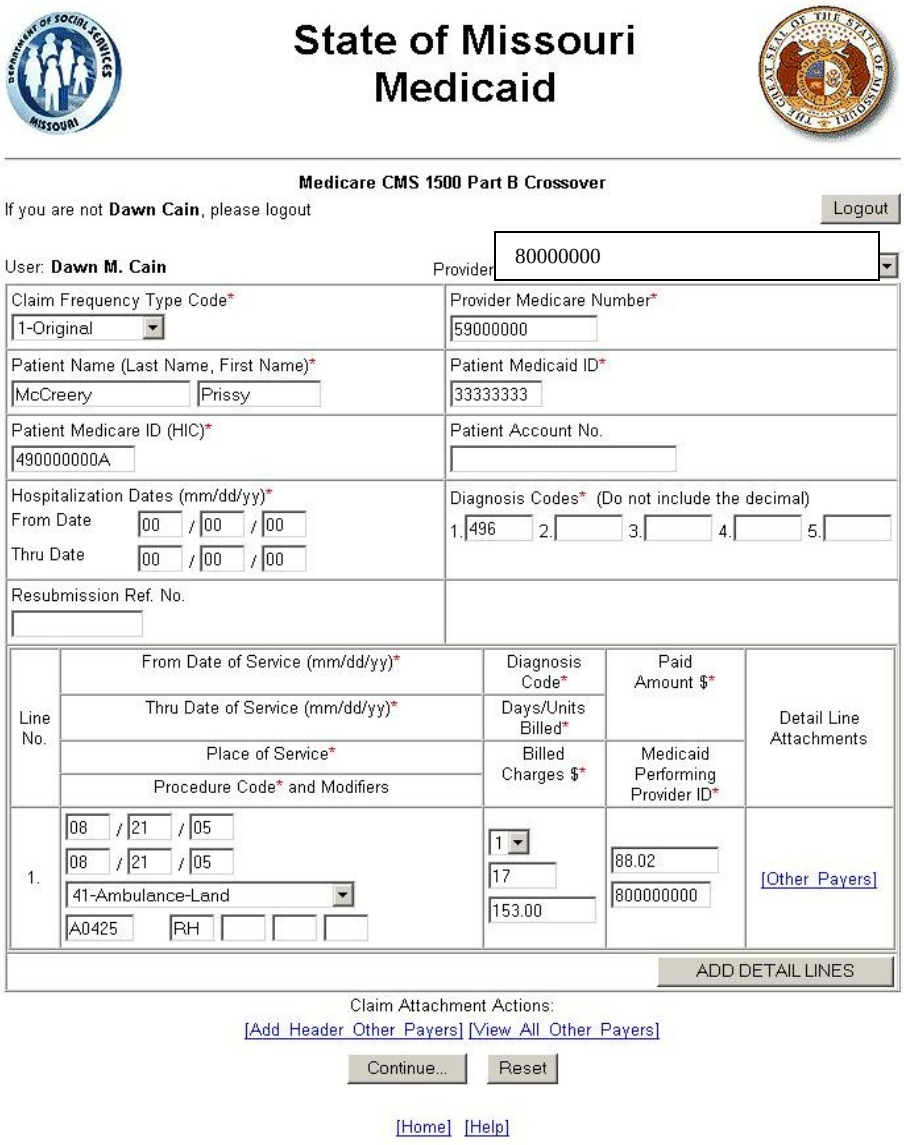
MEDICARE
REMITTANCE
NOTICE

PROVIDER: 59000000
PAGE #: 1 OF 1
DATE: 09/01/05
CHECK/EFT #: 103XXXXXX

ACME AMBULANCE DISTRICT
P.O. BOX 3XY
HOMETOWN, MO 650X8

PERF PROV.	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME: MC CREERY, PRISSY		HIC: 490000000A				ACNT:		ICN 2400000000000		ASG Y HOA HA01	HA18
590000000	0821 082105	41	17	A0425	RH	153.00	110.03	0.00	22.01 CO-42	42.97	88.02
590000000	0821 082105	41	1	A0427	RH	475.00	328.87	0.00	65.77 CO-42	146.13	263.10
PT RESP	87.78			CLAIM TOTALS		628.00	438.90	0.00	87.78	189.10	351.12
CLAIM INFORMATION FORWARD TO: MO STATE MEDICAL CARE											351.12 NET

- **Using this example of a Medicare EOB, the following pages will guide you step-by-step through the process to file your Crossover Claim through the Medicaid billing Web site at www.emomed.com to collect the Medicare deductible and/or coinsurance amounts.**



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not **Dawn Cain**, please logout — Logout

User: **Dawn M. Cain** — Provider: 80000000

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 59000000
Patient Name (Last Name, First Name)*: McCreery, Prissy	Patient Medicaid ID*: 33333333
Patient Medicare ID (HIC)*: 490000000A	Patient Account No.:
Hospitalization Dates (mm/dd/yy)*: From Date 00/00/00, Thru Date 00/00/00	Diagnosis Codes* (Do not include the decimal): 1. 496 2. 3. 4. 5.
Resubmission Ref. No.:	

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)*	Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed*	Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Line Attachments
1.	08/21/05 – 08/21/05	41-Ambulance-Land; A0425 RH	1 / 17	153.00	88.02 / 800000000	[Other Payers]

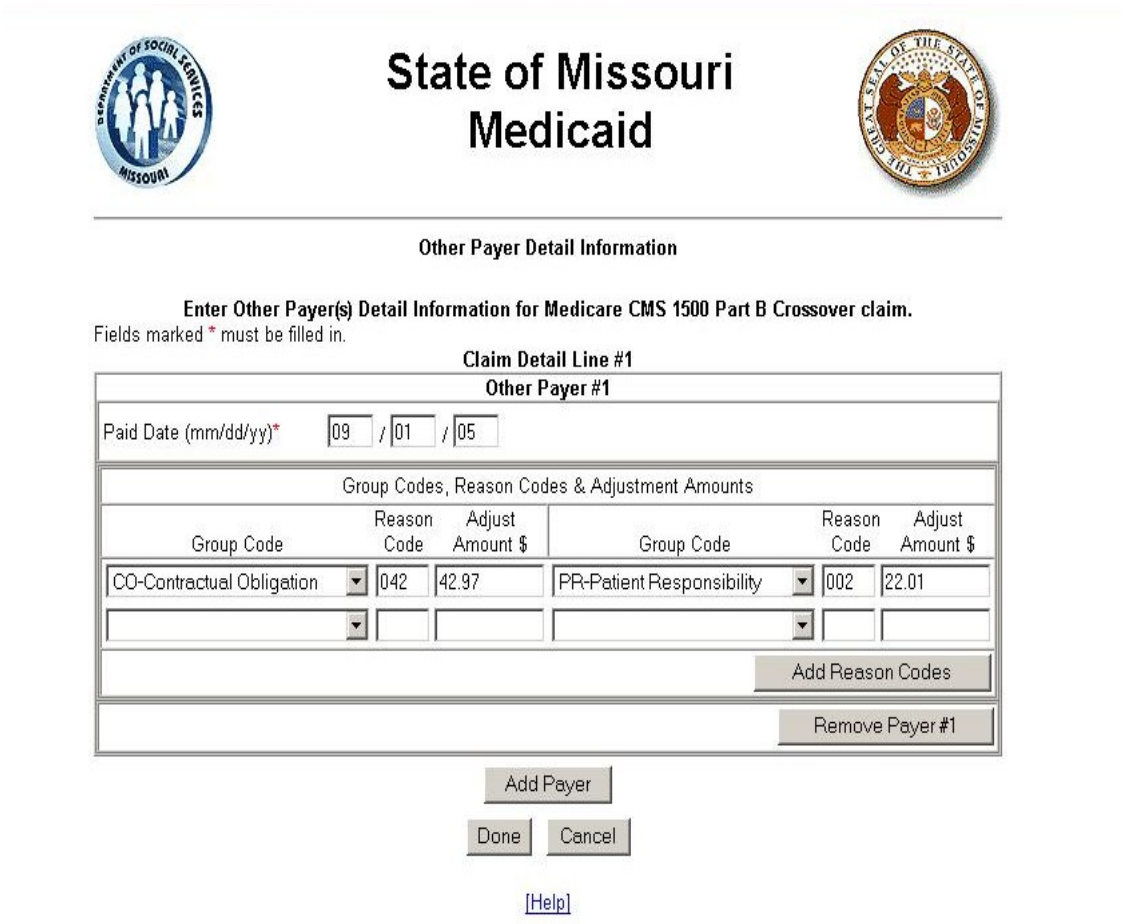
ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **At the Medicaid billing Web site, click on "Medicare CMS 1500 Part B Crossover". This brings you to the above screen. Scroll to the bottom and click on the "Help" button, print and save the instructions.**
- **Complete the information on this screen as shown above using the Medicare EOB. Complete all fields with an asterisk through the first line item detail. Once the first line item has been completed, click on "Other Payers".**



State of Missouri
Medicaid

Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare CMS 1500 Part B Crossover claim.
Fields marked * must be filled in.

Claim Detail Line #1

Other Payer #1

Paid Date (mm/dd/yy)* 09 / 01 / 05

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO-Contractual Obligation	042	42.97	PR-Patient Responsibility	002	22.01

Add Reason Codes

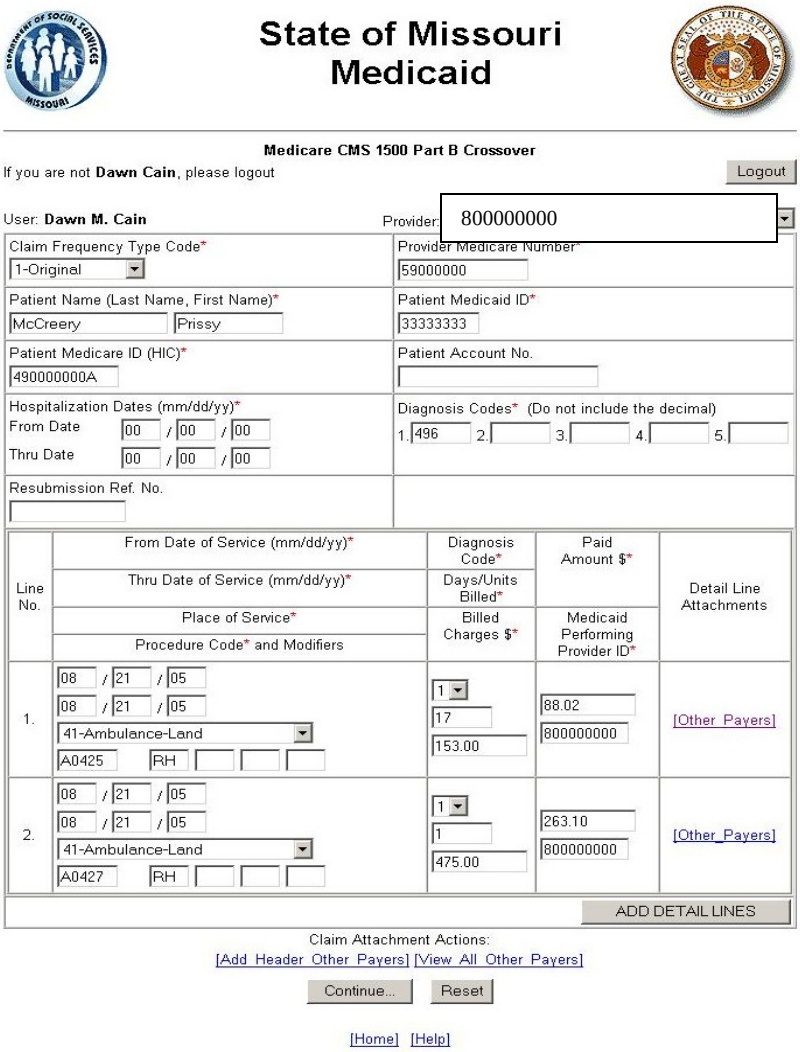
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **This is the Other Payer Detail Screen. You must complete an Other Payer Detail screen for each line item of your claim. Scroll to the bottom and click on the "Help" button, print and save the instructions.**
- **Scroll back to the top, complete the Medicare paid date information as well as the Group and Reason Codes and Adjustment amounts for line #1. If the reason codes are not listed on your Medicare EOB, choose the most appropriate code(s) from the list of "Claim Adjustment Reason Code" from the HIPAA Related Code List. For example, the code on the "Claim Adjustment Reason Code" list for deductible is 1; for coinsurance the code is 2. You would then enter a Reason Code of 001 for deductible amounts and Reason code 002 for coinsurance amounts. In the above example, the provider should report CO-42 and $42.97 as shown on the sample EOMB for line 1.**
- **The "Adjust Amount" should reflect any amount not paid by Medicare including deductible, coinsurance and any non-allowed amounts. When finished, click "Done" to return to the original screen.**



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not **Dawn Cain**, please logout — Logout

User: **Dawn M. Cain** — Provider: 800000000

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 59000000
Patient Name (Last Name, First Name)*: McCreery, Prissy	Patient Medicaid ID*: 33333333
Patient Medicare ID (HIC)*: 490000000A	Patient Account No.:
Hospitalization Dates (mm/dd/yy)*: From Date 00/00/00, Thru Date 00/00/00	Diagnosis Codes* (Do not include the decimal): 1. 496 2. 3. 4. 5.
Resubmission Ref. No.:	

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)* / Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed* / Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Line Attachments
1.	08/21/05 – 08/21/05 – 41-Ambulance-Land – A0425 RH	1 / 17 / 153.00	88.02 / 800000000	[Other Payers]
2.	08/21/05 – 08/21/05 – 41-Ambulance-Land – A0427 RH	1 / 1 / 475.00	263.10 / 800000000	[Other Payers]

ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **When you are back on the original screen, click on "Add Detail Lines" to add additional line items. Enter the information from each additional line from your Medicare EOB. After entering the data on the screen, click on "Other Payers" to get a new screen for "Claim Detail Line #2".**

State of Missouri
Medicaid

Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare CMS 1500 Part B Crossover claim.
Fields marked * must be filled in.

Claim Detail Line #2

Other Payer #1

Paid Date (mm/dd/yy)* 09 / 01 / 05

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO-Contractual Obligation	042	146.13	PR-Patient Responsibility	002	65.77

Add Reason Codes

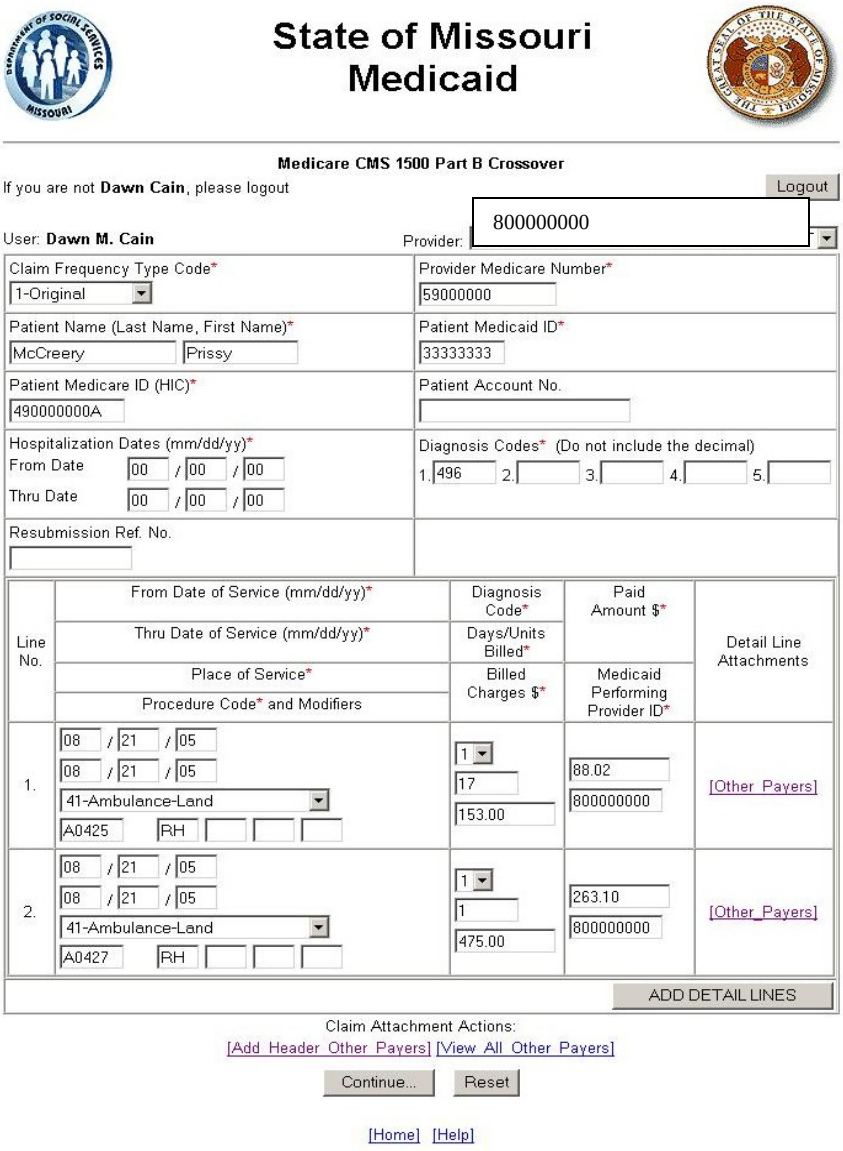
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **For each line item from your Medicare EOB, you must enter an "Other Payer Detail Screen".**
- **The above is an example of the detail entry for line 2 showing both contractual and patient responsibility codes and amounts.**
- **When finished entering the claim detail information, click "Done" to return to the original screen.**



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not **Dawn Cain**, please logout — Logout

User: **Dawn M. Cain** — Provider: 800000000

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 59000000
Patient Name (Last Name, First Name)*: McCreery, Prissy	Patient Medicaid ID*: 33333333
Patient Medicare ID (HIC)*: 490000000A	Patient Account No.:
Hospitalization Dates (mm/dd/yy)*: From Date 00/00/00, Thru Date 00/00/00	Diagnosis Codes* (Do not include the decimal): 1. 496 2. 3. 4. 5.
Resubmission Ref. No.:	

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)* / Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed* / Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Line Attachments
1.	08/21/05 – 08/21/05 – 41-Ambulance-Land – A0425 RH	1 / 17 / 153.00	88.02 / 800000000	[Other Payers]
2.	08/21/05 – 08/21/05 – 41-Ambulance-Land – A0427 RH	1 / 1 / 475.00	263.10 / 800000000	[Other Payers]

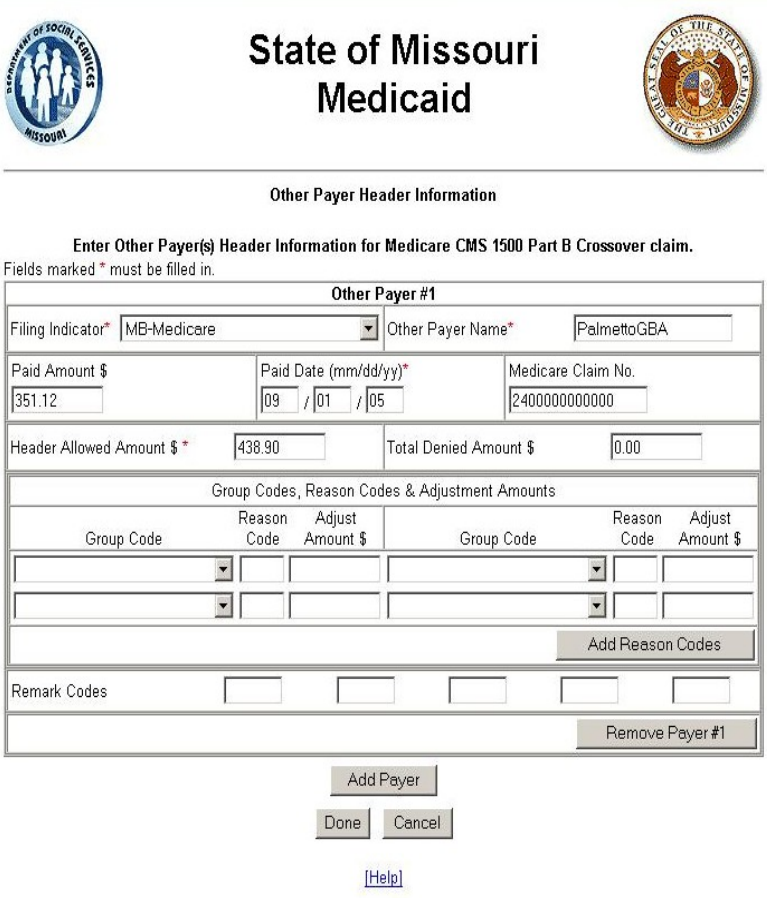
ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **At this point you have completed each detail line from your Medicare EOB and an "Other Payer" screen for each detail line. Click on "Add Header Other Payers".**



State of Missouri
Medicaid

Other Payer Header Information

Enter Other Payer(s) Header Information for Medicare CMS 1500 Part B Crossover claim.

Fields marked * must be filled in.

Other Payer #1

Filing Indicator* MB-Medicare | Other Payer Name* PalmettoGBA

Paid Amount $ 351.12 | Paid Date (mm/dd/yy)* 09 / 01 / 05 | Medicare Claim No. 2400000000000

Header Allowed Amount $ * 438.90 | Total Denied Amount $ 0.00

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $

Add Reason Codes

Remark Codes

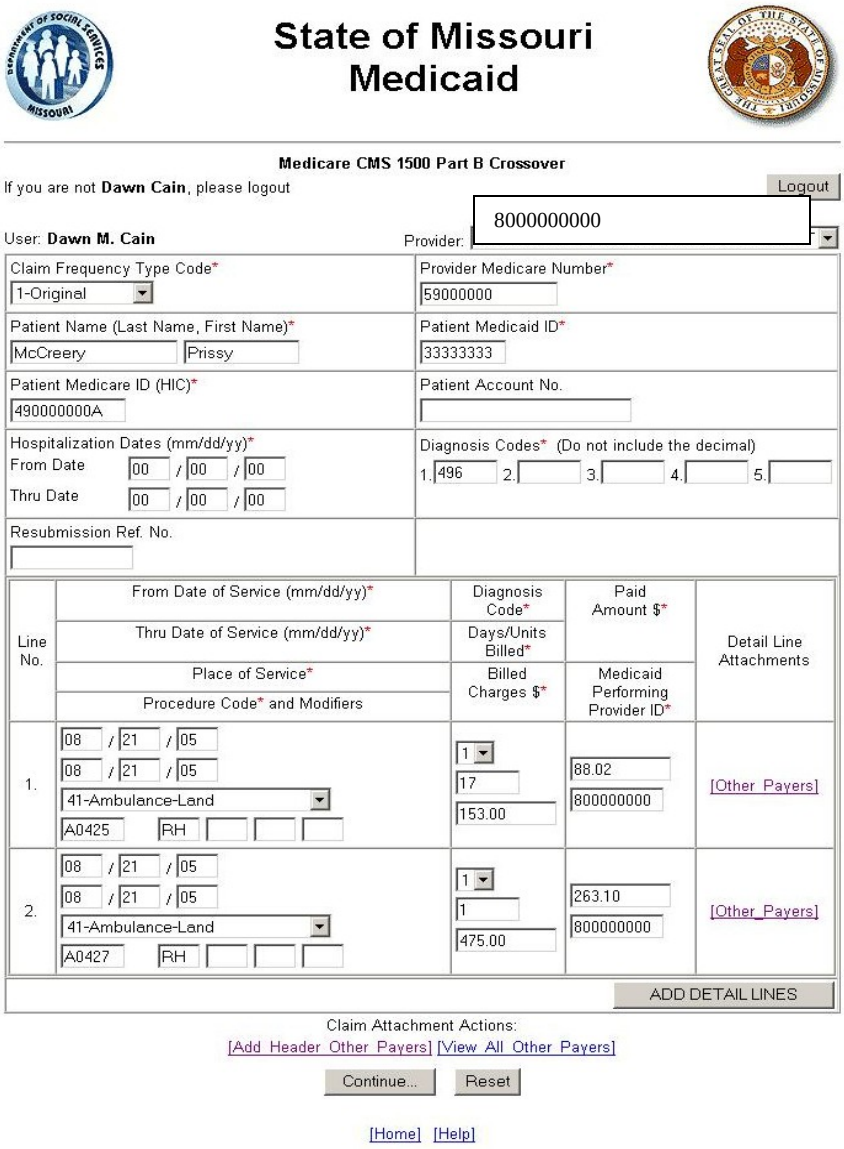
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **You are now on the "Other Payer Header" screen. Scroll down to the bottom of the screen and click on the "Help" button, print and save the instructions.**
- **Scroll back to the top of the form and complete the information as shown. For Part B crossover claims, you do not complete the Group Codes, Reason Codes and Adjustment Amounts information. The Header Allowed Amount will always be the last field you will complete on the "Other Payer Header" screen. When completed, click on "Done" to return to the previous page.**



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not **Dawn Cain**, please logout — Logout

8000000000

User: **Dawn M. Cain** Provider:

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 59000000
Patient Name (Last Name, First Name)*: McCreery, Prissy	Patient Medicaid ID*: 33333333
Patient Medicare ID (HIC)*: 490000000A	Patient Account No.:
Hospitalization Dates (mm/dd/yy)*: From Date 00/00/00, Thru Date 00/00/00	Diagnosis Codes* (Do not include the decimal): 1. 496 2. 3. 4. 5.
Resubmission Ref. No.:	

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)* / Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed* / Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Line Attachments
1.	08/21/05 – 08/21/05 – 41-Ambulance-Land – A0425 RH	1 / 17 / 153.00	88.02 / 800000000	[Other Payers]
2.	08/21/05 – 08/21/05 – 41-Ambulance-Land – A0427 RH	1 / 1 / 475.00	263.10 / 800000000	[Other Payers]

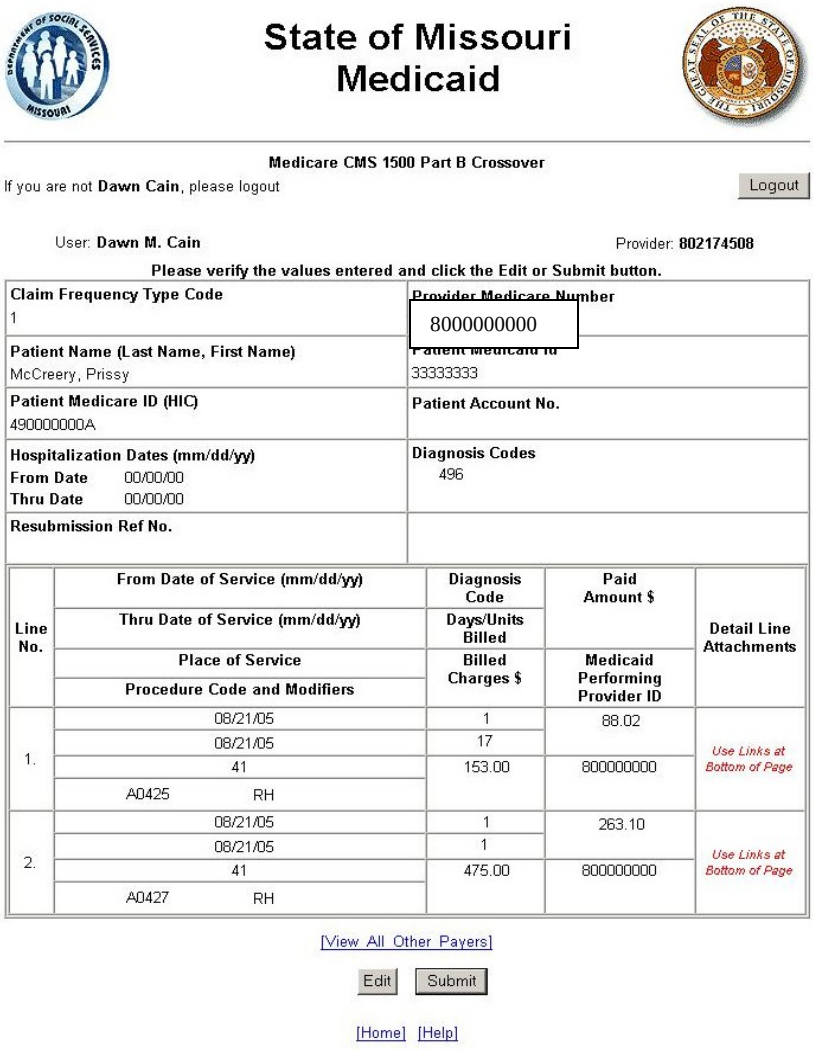
ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **At this point all line detail information, Other Payers and the Header Other Payer has been entered. Click on "Continue".**



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not **Dawn Cain**, please logout — Logout

User: **Dawn M. Cain** Provider: **802174508**

Please verify the values entered and click the Edit or Submit button.

Claim Frequency Type Code 1	**Provider Medicare Number** 8000000000
Patient Name (Last Name, First Name) McCreery, Prissy	**Patient Medicaid Id** 33333333
Patient Medicare ID (HIC) 490000000A	**Patient Account No.**
Hospitalization Dates (mm/dd/yy) **From Date** 00/00/00 **Thru Date** 00/00/00	**Diagnosis Codes** 496
Resubmission Ref No.	

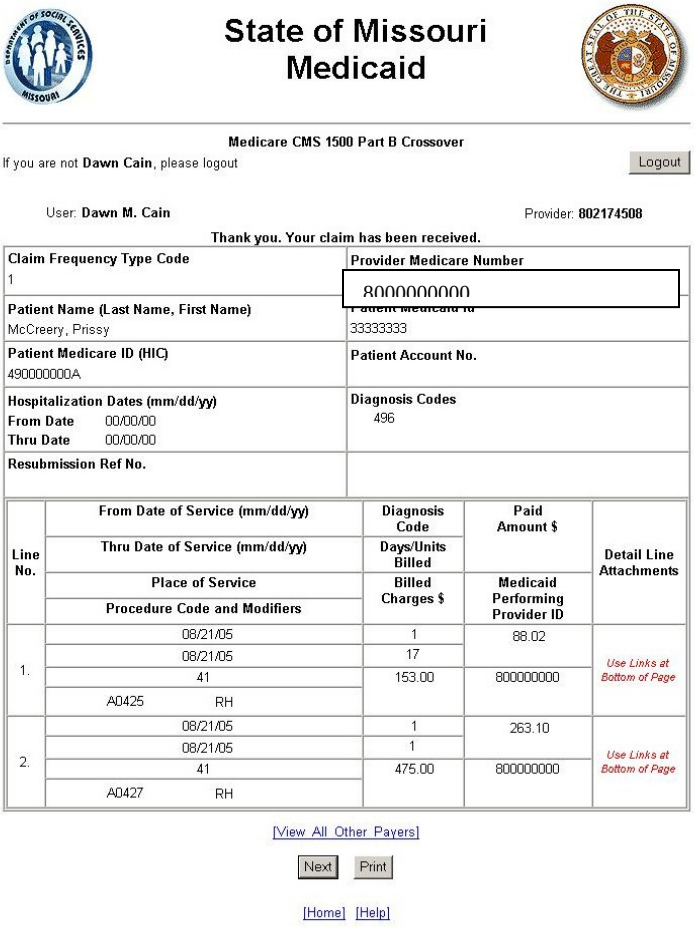
Line No.	From Date of Service (mm/dd/yy) / Thru Date of Service (mm/dd/yy) / Place of Service / Procedure Code and Modifiers	Diagnosis Code / Days/Units Billed / Billed Charges $	Paid Amount $ / Medicaid Performing Provider ID	Detail Line Attachments
1.	08/21/05 08/21/05 41 A0425 RH	1 17 153.00	88.02 800000000	Use Links at Bottom of Page
2.	08/21/05 08/21/05 41 A0427 RH	1 1 475.00	263.10 800000000	Use Links at Bottom of Page

[View All Other Payers]

Edit Submit

[Home] [Help]

- **You are now on the screen to verify the information entered. Scroll to the bottom of the screen and click "Help", print and save the instructions.**
- **You can either edit the information or submit. Click on "Submit" if all information is accurate.**



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not **Dawn Cain**, please logout [Logout]

User: **Dawn M. Cain** Provider: **802174508**

Thank you. Your claim has been received.

Claim Frequency Type Code 1	**Provider Medicare Number** 8000000000
Patient Name (Last Name, First Name) McCreery, Prissy	**Patient Medicaid Id** 33333333
Patient Medicare ID (HIC) 490000000A	**Patient Account No.**
Hospitalization Dates (mm/dd/yy) **From Date** 00/00/00 **Thru Date** 00/00/00	**Diagnosis Codes** 496
Resubmission Ref No.	

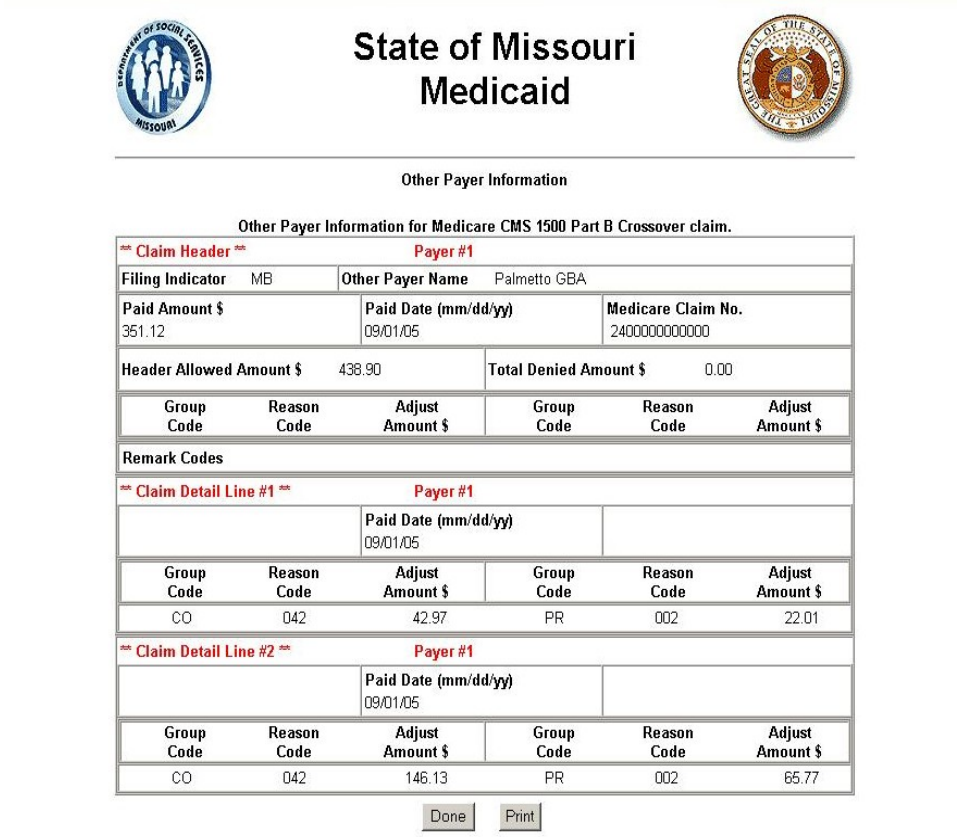
Line No.	From Date of Service (mm/dd/yy) Thru Date of Service (mm/dd/yy) Place of Service Procedure Code and Modifiers	Diagnosis Code Days/Units Billed Billed Charges $	Paid Amount $ Medicaid Performing Provider ID	Detail Line Attachments
1.	08/21/05 08/21/05 41 A0425 RH	1 17 153.00	88.02 800000000	Use Links at Bottom of Page
2.	08/21/05 08/21/05 41 A0427 RH	1 1 475.00	263.10 800000000	Use Links at Bottom of Page

[View All Other Payers]

[Next] [Print]

[Home] [Help]

- **After submitting your claim, you will be brought to a screen which states, "Thank you. Your claim has been received". You may click on the "Print" button at the bottom of the screen to print and save this page for your records.**
- **Click on "View All Other Payers".**



State of Missouri
Medicaid

Other Payer Information

Other Payer Information for Medicare CMS 1500 Part B Crossover claim.

** Claim Header **		Payer #1			
Filing Indicator MB		Other Payer Name Palmetto GBA			
Paid Amount $ 351.12		Paid Date (mm/dd/yy) 09/01/05		Medicare Claim No. 2400000000000	
Header Allowed Amount $ 438.90			Total Denied Amount $ 0.00		
Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
Remark Codes					
** Claim Detail Line #1 **		Payer #1			
		Paid Date (mm/dd/yy) 09/01/05			
Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	042	42.97	PR	002	22.01
** Claim Detail Line #2 **		Payer #1			
		Paid Date (mm/dd/yy) 09/01/05			
Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	042	146.13	PR	002	65.77

Done Print

- **You can click on "Print" to save the Claim Header and Claim Detail for your records.**
- **Clicking on "Done" will take you back to the previous screen where you can either go back to the emomed home page or click on "Next" to enter a new claim.**

SECTION 5
ADJUSTMENT

Providers who are paid incorrectly for a claim should use the *Individual Adjustment Request* form to request an adjustment. Providers may also submit an individual adjustment via the Infocrossing Internet service at *www.emomed.com*, by using the claim frequency type code 7 for a replacement or code 8 for a void. Adjustments may not be requested when the net difference in payment is less than $4.00 per claim or $.25 for pharmacy claims. If the adjustment is due to an insurance payment, or involves Medicare, the $4.00 or $.25, minimum limitation does not apply.

In some instances, more than one change may be necessary on a claim. **All** the changes to the claim must be addressed on the same *Individual Adjustment Request* form. Specify all the necessary changes, listing each change separately. Field 15 of the form may be used to provide additional information. **Only one claim can be processed per *Individual Adjustment Request* form as each adjustment request can only address one particular claim.** A separate *Individual Adjustment Request* form must be completed for each claim that requires changes, even if the changes or errors are of a similar nature or are for the same patient.

When using the Infocrossing Internet service to replace a paid claim using claim frequency type code 7, each line of the original paid claim must be re-entered even though a certain line, or lines, may not require adjusting. A reprocessed Internet claim will have an ICN that begins with a “49”. Claim frequency type code 8 is to be used only to void a previously paid claim and the payment is to be recouped. Claims voided through the Internet will appear on the next remittance advice with an ICN beginning with a “70”.

If an adjustment does not appear on a Remittance Advice within 90 days of submission, a copy of the original *Individual Adjustment Request* and attachments should be resubmitted. Legible photocopies are acceptable. Mark this copy with the word “Tracer”. Submitting another request without indicating it as a “tracer” can further delay processing. Adjustments for claim credits submitted via the Internet get a confirmation back the next day after submission to confirm the acceptance and indicate the status of the adjustment. If the Internal Control Number (ICN) on the credit adjustment is not valid, the confirmation file indicates such. If no confirmation is received, the provider should resubmit the claim credit.

See Section 4 of the Medicaid *Provider Manual* for timely filing requirements for adjustments and claim resubmissions. *Individual Adjustment Request* forms are to be submitted to the address shown on the form.

MISSOURI MEDICAID
INDIVIDUAL ADJUSTMENT REQUEST

☐ UNDERPAYMENT

☐ OVERPAYMENT

FORWARD ORIGINAL TO:

DIV. OF MEDICAL SERVICES
ADJUSTMENT UNIT
P.O. BOX 6500
JEFFERSON CITY, MO 65102

TO FACILITATE PROCESSING, PLEASE ATTACH THE FOLLOWING:

1. Claim Copy
2. Remittance Advice Copy

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE

3. INTERNAL CONTROL NUMBER

4. RECIPIENT MEDICAID NUMBER

5. PROVIDER LABEL

6. RECIPIENT NAME _____

7. REMITTANCE ADVICE DATE _____

R.A. PAGE NUMBER _____

REFER TO PROVIDER MANUAL ADJUSTMENT SECTION FOR INSTRUCTIONS

	SERVICE DATE	INFORMATION ON REMITTANCE ADVICE	CORRECTED INFORMATION
8. QTY/UNITS			
9. NDC/PROCEDURE CODE			
10. SERVICE DATE(S)			
11. BILLED AMOUNT			
12. PAID AMOUNT			
13. PATIENT SURPLUS			
14. OTHER RESOURCES (TPL) (IDENTIFY SOURCE)			
15. OTHER/REMARKS			

16. PROVIDER'S SIGNATURE _____ TITLE _____ DATE _____

MO-8810 (12-00)

SECTION 6
BENEFITS AND LIMITATIONS

Missouri Statute 208.152 authorizes Medicaid coverage of emergency ambulance services. Only those transports considered an emergency and made to the *nearest appropriate hospital* are covered and should be submitted to Medicaid for payment. The definition for emergency transport is as follows:

> Emergency services are services required when there is a sudden or unforeseen situation or occurrence or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
> - ❖ Placing the recipient's health in serious jeopardy; or
> - ❖ Serious impairment to bodily functions; or
> - ❖ Serious dysfunction of any bodily organ or part.

"Nearest appropriate hospital" is the hospital equipped and staffed to provide the needed care for the illness or injury involved. It is the institution, its equipment, its personnel and its capability to provide the service necessary to support the required medical care that determines whether it has appropriate facilities. The fact a more distant institution is better equipped, either qualitatively or quantitatively, to care for the recipient does not in itself support a conclusion a closer institution does not have appropriate facilities. Medicaid does not allow transportation to a more distant facility solely to avail a recipient of the services of a specific physician or family or personal preferences when considering the "nearest appropriate facility".

This policy can be found in section 13.3.A of the MO Medicaid Ambulance manual found on the DMS Web site, www.dss.mo.gov/dms. To access the manual, click on the Providers link on this page, then click on Provider Manuals at the bottom of the Provider Participation page. Exceptions to this policy can be found in sections 13.3.P, Healthy Children and Youth (HCY) services; 13.3.O, transfer of recipients to another hospital; and 13.3.L, transports for specialized testing.

Services not considered emergent or within the exempted categories should not be submitted to Medicaid for processing. Non-emergent trips, as well as services provided to a recipient not Medicaid eligible on the date of the transport, may be billed to the recipient. Medicaid recipients who dispute a bill from an ambulance provider may contact the Medicaid Recipient Services Unit (RSU) at 1-800-392-2161. It is not the responsibility of the ambulance provider to submit a claim to Medicaid in order to receive a denial before billing the recipient.

If the recipient contacts RSU regarding a bill, the ambulance provider may be contacted by RSU staff requesting a copy of the trip ticket. This documentation must be sent to RSU by the requested date in their letter. A medical consultant then reviews the trip

ticket. After review, both the ambulance provider and the recipient will receive written notification. If the review determines the transport meets the emergency criteria, the provider will be instructed to submit the claim to Medicaid and the recipient is not financially responsible. If the review determines the transport does not meet policy, the recipient is notified they are responsible for payment of the bill. **If the ambulance provider does not comply with RSU's request for documentation, the recipient is notified they are not responsible for payment of the bill.**

A list of non-covered ground and air ambulance services can be found in section 13.3.U of the Medicaid provider ambulance manual.

HEALTHY CHILDREN AND YOUTH (HCY) SERVICES

Missouri Medicaid covers medically necessary ambulance services for recipients under 21 years of age through the HCY program. Transport by ambulance is only covered if it is medically necessary and any other method of transportation would endanger the child's health. Examples include a child in a full body cast or having a tracheotomy requiring ventilatory assistance. A trip ticket documenting the ambulance trip was medically necessary must be attached to the claim form. HCY services are identified by the "EP" modifier. Any ambulance trip not meeting the emergency services definition according to Medicaid policy but is medically necessary for a recipient under 21 ***must*** use the "EP" modifier with the appropriate ambulance procedure code. Transports for the under 21 population meeting the definition of emergency services ***must not*** use the "EP" modifier.

If a recipient under 21 needs to be transported from one hospital to another for treatment or specialized testing and the transfer meets Medicaid policy (reference sections 13.3.L through 13.3.O of the Medicaid provider ambulance manual), the trip is a covered service. In these cases, the "EP" modifier is ***not*** used.

TRIP TICKET REQUIREMENTS

Effective February 1, 2006, the required submission of a trip ticket with the claim was removed under the following circumstances:

- Air ambulance transports;
- Transports for deceased individuals;
- Transports for multiple recipients; and
- Two trips in one day.

Providers are required to maintain all trip documentation in the recipient's file. As stated above, trip tickets for HCY services are required.

Ambulance providers who are on prepayment review must continue to file paper claims attaching the trip ticket and all appropriate and necessary documentation.

HOSPITAL TO HOSPITAL TRANSFERS

Ambulance transfers of recipients from one hospital to another hospital to receive inpatient medically necessary services not available at the first facility are covered by Medicaid. Hospital transfers shall be covered when the recipient has been stabilized at the first hospital, but needs a higher level of care available only at the second hospital. Examples of medically necessary transfers include services such as rehabilitation, a burn unit, ventilator assistance or other specialized care. ***Transport from a hospital capable of treating the recipient because the recipient and/or the recipient's family prefer a specific hospital or physician is not a covered service.***

TRANSPORTS TO TWO DIFFERENT HOSPITALS

Medicaid covers transportation from the point of pickup to two different hospitals made on the same day by the same ambulance provider when it is medically necessary. This situation happens when the ambulance transports to the nearest hospital, but before the recipient leaves the emergency room it is decided the first hospital is not appropriate and the recipient is transported to a second hospital. When it is medically necessary to transport a recipient from one hospital to another on the same date of service, providers must bill the base rate procedure code with a quantity of "2". Mileage and any ancillary charges for both trips are to be combined.

TWO TRIPS ON THE SAME DATE OF SERVICE

Two emergency ambulance trips to a hospital in one day for the same recipient may be covered when medically necessary. Proper trip documentation must be maintained in the recipient's record. To bill for two trips on the same day, the same provider must show a quantity of "2" units for the base rate procedure code. Mileage and any ancillary charges for both trips are to be combined. If one trip one trip is ALS (advanced life support) and one trip is BLS (basic life support), each trip should be billed on the same claim with the appropriate base rate procedure codes.

If two different ambulance services transport the same recipient on the same date of service, both providers must maintain proper trip documentation in the recipient's record to substantiate medical necessity.

TRANSPORT FOR SPECIALIZED TESTING

Transporting from one hospital to another hospital and return for specialized testing and/or treatment is covered for ground ambulance. One base charge is payable even though two separate trips or waiting time may be involved. The appropriate place of service when billing for specialized testing and/or treatment is 21 (inpatient hospital) since the hospital is both the point of pickup and final destination after receiving

services at the diagnostic or therapeutic site. Mileage may be billed if recipient transport from point of pickup to the destination and back is more than five miles. Use procedure code A0428HD to bill for transportation for specialized testing and/or treatment.

Transport from one medical facility to another for specialized testing and/or treatment is non-covered for emergency air ambulance services.

DECEASED RECIPIENTS

An individual is considered to have expired as of the time the individual is pronounced dead by a person who is legally authorized to make such a pronouncement, usually a physician.

- If the recipient was pronounced dead *before* the ambulance was called, no Medicaid payment is made.
- If the recipient was pronounced dead *after* the ambulance was called but prior to arrival at the scene, payment may only be made for mileage from the base to the point of pickup. Transport from point of pickup to destination is not payable; the base rate is not reimbursable.
- If the recipient was pronounced after the ambulance arrived on the scene but prior to transport and life saving measures were performed at the scene, the base rate and mileage from base to point of pickup may be covered. ALS level 1 or 2 must be documented in the recipient's trip documentation (reference section 13.3.D of the Medicaid provider ambulance manual for ALS level 1 and 2 service definitions).
- If the recipient was pronounced dead while enroute to or upon arrival at the destination, the base rate and mileage from point of pickup to the destination may be covered. ALS level 1 or 2 must be documented in the recipient's trip documentation.

VALID AMBULANCE MODIFIERS

EP – HCY services for recipients under 21 years of age
GM – Ground transport for multiple recipients
HH – Hospital to hospital transfer
HD – Specialized testing and/or treatment

A complete list of covered procedure codes can be found in section 19 of the Medicaid provider ambulance manual.

SECTION 7
RESOURCE PUBLICATIONS FOR PROVIDERS

ICD-9-CM & Health Care Procedure Coding System (HCPCS)

The *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9) is the publication used for proper diagnostic coding. The diagnosis code is a required field on claim forms and attachments. The accuracy of the code that describes the patient's condition is important.

Medicaid also uses the *Health Care Procedure Coding System (HCPCS), National Level II*. It is a listing of codes and descriptive terminology used for reporting the provision of supplies, materials, injections and certain services and procedures.

Both of the above publications can be ordered from the following:

Practice Management Information Corporation
4727 Wilshire Blvd. Ste 300
Los Angles, CA 90010
800/633-7467
http://www.pmiconline.com

Ingenix Publications
PO Box 27116
Salt Lake City, UT 84127-0116
800/464-3649
Fax Orders: 801/982-4033
www.IngenixOnline.com

SECTION 8
RECIPIENT LIABILITY
State Regulation 13CSR 70-4.030

If an enrolled Medicaid provider does not want to accept Missouri Medicaid as payment but instead wants the patient (recipient) to be responsible for the payment (be a private pay patient), there must be a written agreement between the patient and the provider in which the patient understands and agrees that Medicaid will not be billed for the service(s) and that the patient is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the patient and the provider. **The written agreement must be prepared prior to the service(s) being rendered.** A copy of the written agreement must be kept in the patient's medical record.

If there is no evidence of this written agreement, the provider cannot bill the patient and must submit a claim to Medicaid for reimbursement for the covered service(s).

If Medicaid denies payment for a service because all policies, rules and regulations of the Missouri Medicaid program were not followed (e.g., Prior Authorization, Second Surgical Opinion, etc.), the patient is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before Medicaid is billed.

MEDICAID RECIPIENT REIMBURSEMENT (MMR)

The Medicaid Recipient Reimbursement program (MMR) is devised to make payment to those recipients whose eligibility for Medicaid benefits has been denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other legal agency decision rendered on or after January 1, 1986.

Recipients are reimbursed for the payments they made to providers for medical services received between the date of their denial and the date of their subsequent establishment of eligibility. The recipient is furnished with special forms to have completed by the provider(s) of service. If Medicaid recipients have any questions, they should call (800) 392-2161.

Nondiscrimination Policy Statement

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS shall take affirmative action to ensure that employees, applicants for employment, clients, potential clients, and contractors are treated equitably regardless of race, color, national origin, sex, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain non-discrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended/ the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability or religion may file a complaint by calling the DSS Office for Civil Rights at 1-800-776-8014. Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

or

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street
Kansas City, MO 64106

Additionally, any person who believes they have been discriminated against in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the United States Department of Agriculture at:

USDA Office of Civil Rights
1400 Independence Ave., SW
Mail Stop 9410
Washington, DC 20250